**Review of ONC Standard & Certification Rule**

March 27, 2012

Larry, John, Brian, Annessa, Cynthia, Sue

ONC Policy FACA Certification and Adoption workgroup looking at three topics within the proposed rule:

* Revised definition of a certified EHR
* Safety enhanced design
* Clinical decision support and info button

Other issues:

* Certification criteria for other health care settings
* 2014 accounting of disclosures
* Disability status
* Data portability
* EHR technology price transparency

**ONC Health Information Technology: Standards, Implementation Specifications, and**

**Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to**

**the Permanent Certification Program for Health Information Technology**

<http://www.ofr.gov/OFRUpload/OFRData/2012-04430_PI.pdf>

P. 53

Consistent with our discussion in the preamble section titled “Explanation and Revision

of Terms Used in Certification Criteria,” we have replaced the terms “modify” and “retrieve” in

the recommended criterion with “change” and “access,” respectively. Further, consistent with

the interpretation we provided in the S&CC July 2010 final rule, we are reiterating and clarifying

that “**longitudinal care”** is used to mean over an extended period of time. For the ambulatory

setting, this would be over multiple office visits. For the inpatient setting, this would be for the

duration of an entire hospitalization, which would include the patient moving to different wards

or units (e.g., emergency department, intensive care, and cardiology) within the hospital during

the hospitalization. The HITSC suggested that we consider longitudinal care to cover multiple

hospitalizations, but we believe this could be difficult to achieve and may not offer added value

based on the duration of time between a patient’s hospitalizations and the reason for the

hospitalizations. To note, our clarification of the meaning of longitudinal care applies equally to

its use in other certification criteria, such as “medication list” and “medication allergy list.” If

we were to change our interpretation of longitudinal care as suggested by the HITSC, it would

apply to these certification criteria as well and could constitute a change in the capabilities

included in the criteria, which in turn would cause them to become revised certification criteria.

We welcome comments on our interpretation of longitudinal care. We also welcome comments

on whether a term other than “longitudinal care” could and should be used to express the

capability required by this certification criterion and the other referenced certification criteria (“medication list” and “medication allergy list”). We understand that the longitudinal care

description we use for the purposes of EHR technology certification may differ from the

meaning that providers attribute to it, including the meaning given to it by the Longitudinal

Coordination of Care Workgroup within the Standards and Interoperability Framework30.

30 <http://wiki.siframework.org/Longitudinal+Coordination+of+Care+WG>

Our definition of longitudinal care:

* Dr. Barr’s (ACP) definition: Best quality of care is when it is a patient centered, physician guided, longitudinal care
* Get a different name other than longitudinal ASK BILL
* Can we offer up a suggestion? A certain number of visits to a doc, or within a single hospitalization, Average LoS,
* Separation within departments in a hospital, boundaries created

p. 54

Therefore, we propose that only SNOMED CT® is an appropriate standard for the recording of patient problems in a problem list. This does not, however, preclude the use of ICD-10-CM for the capture and/or transmission of encounter billing diagnoses. We propose to adopt this revised certification criterion for the 2014 Edition EHR certification criteria at § 170.314(a)(5) and the International Release January 2012 version of SNOMED CT® at § 170.207(a)(3).

S&I LCC workgroup has discussed use of LOINC and SNOMED, ICD-9/10

Problems with using SNOMED in a problem list- submitting a claim. Claims want an ICD code. Mapping from SNOMED to ICD for billing.

Beneficial for LTPAC to go with the rest of the industry if they are moving with SNOMED-CT. SNOMED is part of the NLM, it is free. Toolkits available in the industry.

Nomenclature is more important factor especially with care coordination, ACOs, etc.

PP. 87- 88

The HITSC recommended that we adopt a revised certification criterion for the

ambulatory setting that required the use of RxNorm as the vocabulary standard. We agree that

RxNorm should be adopted as the vocabulary standard instead of the current adopted standard

which specifies any source vocabulary that is included in RxNorm. Additionally, with respect to content exchange standards, we are proposing to no longer include the use of NCPDP SCRIPT version 8.1 as a way to meet the 2014 Edition EHR certification criterion because we understand that CMS is planning to propose retiring this standard (adopted as a Medicare Part D eprescribing standard) in a proposed rule that is scheduled to be issued soon after this proposed rule is published. If we should receive information indicating a change in CMS’ plans prior to the issuance of our final rule, we may, based also on public comment, reinstate this standard in a final revised certification criterion. We believe that it is appropriate for this certification criterion to be adopted for both the ambulatory and inpatient settings (as discussed under the proposed new certification criteria section) as it supports our desired policy and interoperability outcome for content exchange standards to be used when information is exchanged between different legal entities. We propose to adopt this revised certification criterion at § 170.314(b)(3) and the February 6, 2012 Release of the RxNorm standard at § 170.207(h).

Support NCPDP 10.x to support eRx in LTC.

p. 133

As we continue to adopt new and revised certification criteria to support MU, we believe

that it is prudent to seek public comment on whether we should focus our efforts on the

certification of the HIT used by health care providers that are ineligible to receive incentives

under the EHR Incentive Programs. In particular, we are interested in commenters’ thoughts on

whether we should consider adopting certification criteria for other health care settings, such as

the long-term care, post-acute care, and mental and behavioral health settings. For those

commenters that believe we should consider certification criteria for other health care settings,

we respectfully request that their comments specify the certification criteria that would be

appropriate as well as the benefits they believe a regulatory approach would provide. Last, we

ask that the public consider whether the private sector could alternatively address any perceived

need or demand for such certification. For example, we are aware that the Certification

Commission for Health Information Technology (CCHIT) has certification programs for long term and post-acute care as well as behavioral health EHR technology.44

Certification criteria for ineligibles. Is a private sector alternative a suitable option?

ONC does not have authority to dictate cert for ineligibles?

CCHIT would recommend that we self certify that is not as comprehensive, limited Cert that utilizes advice from ONC/CMS/government.

Following the NIST cert criteria for MU? 37 items

HIE, P&S/confidentiality are essential and fundamental, should be core building blocks, should be facilitated if not legislated,

Benefits: clinical decision support, quality outcomes, standardized problem lists, nomenclature, etc. especially important with new care delivery models

Recommendation: Make an easier certification for kernel/sub-set (smaller than base) EHR for non eligible providers. Separate from core cert criteria.

Bare minimum requirements:

* Standardized vocabulary, such as SNOMED, LOINC, RxNORM
* Privacy and security -
* Exchange of health information
* Harmonized quality measures
* discreet data

PP. 135-136

We are interested in whether commenters believe that EHR technology certified to the

2014 Edition EHR certification criteria should be capable of recording the functional, behavioral,

cognitive, and/or disability status of patients (collectively referred to as “disability status”). The

recording of disability status could have many benefits. It could facilitate provider identification

of patients with disabilities and the subsequent provision of appropriate auxiliary aids and

services for those patients by providers. It could also promote and facilitate the exchange of this

type of patient information between providers of care, which could lead to better quality of care

for those with disabilities. Further, the recording of disability status could help monitor

disparities between the “disabled” and “nondisabled” population.

We are specifically requesting comment on whether there exists a standard(s) that would

be appropriate for recording disability status in EHR technology. We are aware of a standard for

disability status approved by the Secretary for use in population health surveys sponsored by

HHS46 and standards under development as part of the Standards and Interoperability Framework

and the Continuity Assessment Record and Evaluation (CARE) assessment tool47. We welcome

comments on whether these standards or any other standards would be appropriate for recording

disability status in EHR technology.

We ask that commenters consider whether the recording of disability status should be a

required or optional capability that EHR technology would include for certification to the 2014

Edition EHR certification criteria. We also ask commenters to consider whether the recording of

disability status should be part of a Base EHR and included in a separate certification criterion or

possibly the “demographics” certification criterion (§ 170.314(a)(3)). Last, we ask commenters

to consider whether disability status recorded according to the standard should also be included

in other certification criteria such as “transitions of care – incorporate summary care record” (§

170.314(b)(1)), “transitions of care – create and transmit summary care record” (§

170.314(b)(2)), “view, download and transmit to 3rd party” (§ 170.314(e)(1)), and “clinical

summaries” (§ 170.314(e)(2)).

OMH disability status questions

Other standards necessary?

Should disability status be recorded as base EHR?

Should cert criteria be included in demographic section?

46 http://www.minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

47 http://wiki.siframework.org/file/detail/CARE+Tool+Functional%2C+Cognitive+and+Skin+Status.xls

pp. 164-165

(5) Problem list. Enable a user to electronically record, change, and access a patient’s

problem list for longitudinal care in accordance with, at a minimum, the version of the

standard specified in § 170.207(a)(3).

(6) Medication list. Enable a user to electronically record, change, and access a patient’s

active medication list as well as medication history for longitudinal care.

(7) Medication allergy list. Enable a user to electronically record, change, and access a

patient’s active medication allergy list as well as medication allergy history for longitudinal

care.